

STATE PLAN FOR MEDICAL ASSISTANCE  
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM

LIMITATIONS

(Continued)

2. B. Rural Health  
Clinics. Serv.  
and other  
Ambulatory Serv.  
furnished by a  
Rural Health  
Clinic

3. Billing time limitations:

- a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service.
- b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:
  - (i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and
  - (ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.
- c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service.
- d. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later.
- e. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined.

See Page 9-2

TN No. 91-16  
Supersedes  
TN No. 84-19

Approval Date APR 10 1991  
Effective Date JAN 28 1991

STATE PLAN FOR MEDICAL ASSISTANCE  
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM	LIMITATIONS
2 c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).	<ol style="list-style-type: none"><li>1. Same as rural health clinic services limited to the Federal requirements 42 CFR Parts 405, 449, 450, 481.</li><li>2. Other ambulatory services limited by specific programs covered in the Maryland State Plan numbered: 3, 4.B., 4.C., 6.a, 6.b., 10., 11.a., 12.a., 12.d., 17.a., 18.</li><li>3. Billing Time Limitations<ol style="list-style-type: none"><li>a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service.</li><li>b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:<ol style="list-style-type: none"><li>(i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and</li></ol></li></ol></li></ol>

See Page 9-2

TN # 91-15

Supersedes Approval Date  
TN # \_\_\_\_\_

SEP 19 1991

Effective Date

APR 1 1991

STATE PLAN FOR MEDICAL ASSISTANCE  
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM	LIMITATIONS
Continued 2c. Federally qualified health center (FGHC) services and other ambulatory services that are covered under the plan and furnished by an FGHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).	(ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.  c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service.  d. A claim which is rejected for payment due to improper completion or incomplete information, shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6-month period, or within 60 days of rejection, whichever is later.  e. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined.

See Page 9-2

TN # 91-15

SEP 19 1991

Supersedes Approval Date \_\_\_\_\_  
TN # \_\_\_\_\_

Effective Date APR 01 1991

STATE PLAN FOR MEDICAL ASSISTANCE  
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

## PROGRAM

## LIMITATIONS

3. Other Laboratory and  
X-ray Services

The following are not covered:

1. Services for which there does not exist an order signed by a physician, dentist, or podiatrist.
2. Repealed - effective 8-12-85.
3. Services denied by Medicare as not medically necessary.
4. Procedures for which the laboratory has not been certified by Medicare.
5. Procedures that the provider knows or should know are investigational or experimental in nature.
6. Services included and paid for by the Program as part of the charge made by an inpatient facility, hospital outpatient department, or free-standing clinic.
7. Laboratory services related to autopsies.
8. Laboratory work associated with sex change, unless the treatment has been preauthorized.
9. Billing time limitations:
  - a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service.
  - b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:
    - (i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and

TN No. 91-16  
Supersedes  
TN No. 86-4

Approval Date APR 10 1991

Effective Date JAN 28 1991

STATE PLAN FOR MEDICAL ASSISTANCE  
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM

LIMITATIONS

4. a. Skilled nursing  
facility services  
(other than services  
in an institution for  
tuberculosis or mental  
diseases but including  
recipients under 21  
of age )

1. Billing Time Limitations

a. The Department may not reimburse the claims  
received by the Program for payment more than 6  
months after the date of service.

b. Medicare Claims. For any claim initially  
submitted to Medicare and for which services have  
been:

(i) Approved, requests for reimbursement shall  
be submitted and received by the Program within  
6 months of the date of service or 60 days from  
the Medicare remittance date, as shown on the  
Explanation of Medicare Benefits, whichever is  
later; and

(ii) Denied, requests for reimbursement shall be  
submitted and received by the Program within 6  
months of the date of service or 60 days from the  
Medicare remittance date, as shown on the  
Explanation of Medicare Benefits, whichever is  
later.

c. A claim for services provided on different dates  
and submitted on a single form shall be paid only  
if it is received by the Program within 6 months of  
the earliest date of service.

d. A claim which is rejected for payment due to  
improper completion or incomplete information shall  
be paid only if it is properly completed,  
resubmitted, and received by the Program within the  
original 6 month period, or within 60 days of  
rejection, whichever is later.

e. Claims submitted after the time limitations  
because of a retroactive eligibility determination  
shall be considered for payment if received by the  
Program within 6 months of the date on which  
eligibility was determined.

*See Page 9-2*

TN No. 91-16  
Supersedes  
TN No. 84-19

Approval Date \_\_\_\_\_

Effective Date JAN 28 1991

STATE PLAN FOR MEDICAL ASSISTANCE  
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

2. Bed reservations for recipients who are not on a leave of absence to visit with friends or relatives or to participate in State approved therapeutic or rehabilitative programs for a maximum of 18 days in any calendar year and without any limitations on the number of days per visit.
3. Bed reservations for recipients hospitalized for an acute condition, exceeding 15 days per hospital visit.
4. Administrative days not approved by the Department or its designee.
5. Audiology services.
6. Occupational therapy services, unless part of a specialized rehabilitative therapy services program.
7. Physical therapy services, unless part of a specialized rehabilitative therapy services program.
8. Speech therapy services.
9. Services for which payment is made directly to a provider other than the nursing facility.
10. Services by an out-of-state long-term facility unless a provider agreement is executed by the Department and the long-term care facility.

SEP 18 1984

SEP 10 1984

STATE PLAN FOR MEDICAL ASSISTANCE  
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

Programs	Limitations
Services that require preauthorization	The Department of Human Resources will certify the recipient for financial eligibility, and the Department or its designee will certify the recipient as requiring skilled nursing facility services, except when Administrative days are applicable. The Department or its designee will certify as requiring skilled nursing facility services only those financially eligible patients having complicated medical or surgical problems which require direct care by registered nurses on all shifts 7 days a week.

STATE PLAN FOR MEDICAL ASSISTANCE  
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

Program	Limitations
4.B. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.	<ol style="list-style-type: none"> <li>1. EPSDT screening and treatment invoices should be submitted for payment within 60 days, but no later than 9 months, from the date of service. Billing time limitations:               <ol style="list-style-type: none"> <li>a. The Department may not reimburse the claims received by the Program for payment more than 9 months after the date of service.</li> <li>b. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 9 months of the earliest date of service.</li> <li>c. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 9 month period, or within 60 days of rejection, whichever is later.</li> <li>d. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 9 months of the date on which eligibility was determined.</li> </ol> </li> <li>2. Any limits on services or treatments in other sections of the State Plan are not applicable for individuals under 21 years when it is shown that the treatment or services is medically necessary to correct or lessen health problems detected or suspected by the screening service.</li> </ol>

TN No. 96-10

Supersedes

TN No. 93-12

JUL 23 1996

 Approval Date \_\_\_\_\_

APR 01 1996

 Effective Date \_\_\_\_\_

STATE PLAN FOR MEDICAL ASSISTANCE  
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

Program	Limitations
4.B. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found	<p>3. EPSDT participants are generally limited to a maximum of one EPSDT screen for each age interval specified by the Schedule of Preventive Health Care. However, the Program allows additional screening as deemed necessary.</p> <p>4. To receive orthodontic care, an individual case shall score a minimum of 15 points on the Handicapping Labio-Lingual Deviations (HLD) Index #4 and be dysfunctional, as determined by the Department or its designee.</p> <p>5. Audiological and hearing aid services are limited to EPSDT-screened recipients. In general, EPSDT participants are limited to:</p> <ul style="list-style-type: none"> <li>a. One audiological evaluation per year;</li> <li>b. One hearing aid evaluation per dispensed monaural or binaural hearing aid;</li> <li>c. Two replacement ear molds per monaural and four per binaural hearing aids per year.</li> <li>d. Forty-eight batteries per recipient per year with a monaural hearing aid or ninety-six batteries per recipient per year with a binaural hearing aid to be purchased no more frequently than every six months and in quantities of twenty-four or less for a binaural hearing aid.</li> </ul> <p>These limitations will be waived if medical necessity can be justified.</p>

TN No. 96-10  
Supersedes  
TN No. 93-12

JUL 23 1996  
Approval Date \_\_\_\_\_

APR 01 1996  
Effective Date \_\_\_\_\_

STATE PLAN FOR MEDICAL ASSISTANCE  
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

Program	Limitations
4.B. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found	<p>6. Dental services are limited on initial and periodic dental examinations to one per recipient per six month period. This limitation will be waived if medical necessity can be justified. Pit and fissure sealants are covered only for the occlusal surfaces of posterior permanent teeth that are without restorations or decay.</p> <p>7. Vision services including eye examinations and eyeglasses or contact lenses are generally limited to no more than once a year, following a referral from a certified medical EPSDT provider who has performed a vision screening, or a physician or optometrist who has performed an equivalent screening. These limitations will be waived if medical necessity can be justified.</p> <p>8. To participate in the Maryland Medical Assistance Program as an EPSDT referred services provider for alcohol and drug abuse outpatient counseling services, targeted case management services, chiropractic services, in-home therapeutic intervention services, medical day care for medically fragile and technology dependent children, nurse psychotherapy services, nutritional counseling services, occupational therapy services, psychological services, social work services, speech therapy services, and therapeutic nursery services, a provider shall:</p> <p style="margin-left: 40px;">a. Gain approval by the EPSDT screening provider every 6 months for continued treatment. This approval must be documented by the EPSDT screening provider and the EPSDT referred services provider in the recipient's medical record; and</p> <p style="margin-left: 40px;">b. Have experience rendering services to individuals from birth to 21 years old.</p>

TN No. 96-10  
Supersedes  
TN No. 93-12

JUL 23 1996  
Approval Date \_\_\_\_\_

APR 01 1996  
Effective Date \_\_\_\_\_